LOW INCOME UTILIZATION COLLECTION FORM

(Response required by July 1, 2005)

INCOMPLETE forms will be REJECTED

HOSPITAL:

CITY / STATE:

FISCAL YEAR END: , 2003

This form, in addition to audited financial statements and any other supporting documentation, must only be submitted if the hospital's low income utilization rate exceeds 25% for disproportionate share determination.

	Amount	List Attached Financial Statement or Supporting Documentation	List Workpaper Reference (i.e., pg. 1, item 1)
1. TOTAL PAYMENTS RECEIVED DIRECTLY FROM STATE AND LOCAL GOVERNMENTS for all patient services, both inpatient and outpatient	$		
2. TOTAL HOSPITAL NET REVENUE for all patient services, both inpatient and outpatient	$		
3. TOTAL GROSS INPATIENT HOSPITAL CHARGES FOR CHARITY CARE (This must not include unreimbursed cost, contractual allowances, bad debts or discounts, except contractual allowances and discounts for Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent patients. Inpatient charity care charges may be calculated based on the ratio of inpatient to total gross hospital charges if the provider's records do not distinguish inpatient from total charity care).	$		
4. TOTAL HOSPITAL GROSS CHARGES FOR INPATIENT HOSPITAL SERVICES	$		

I CERTIFY that to the best of my knowledge, the above information is true and correct.

This form must be submitted to:

Illinois Department of Public Aid
Bureau of Health Finance
Hospital Audit Section
201 S. Grand Avenue East, 2nd Floor
Springfield, Illinois 62763-0001
Phone (217)782-1630 Fax (217)782-2812

Authorized Signature

Name (Typewritten)

Title (Typewritten)

Date ( ) Phone

Completion of this form or compliance with instructions is voluntary; however failure to do so may affect this Department's action.

Forms approved by the Forms Management Center.